

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATA SURVEY COMPLETED C 09/09/2009
NAME OF PROVIDER OR SUPPLIER MILFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MARVEL ROAD MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from August 31, 2009 through September 9, 2009. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirty-one (131). The sample totaled twenty-four (24) residents which included a review of twenty-one (21) active and three (3) closed residents' clinical records. There was a subsample of 2 residents for observation.	F 000			
F 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the residents' funds account and surety bond for that account, it was determined that the facility failed to assure the security of all personal funds of residents deposited with the facility. Findings include: 1. Review of the residents' funds account and surety bond on 09/07/09 revealed that the surety bond was insufficient to cover the maximum balance of the account. A surety bond rider from 2007 had increased the covered amount to \$80,000. The maximum balance on 07/01/09 was \$93,466.92. An updated rider was put in place on 09/09/09 to the sum of \$100,000.	F 161	The center did increase the surety bond on 9/9/09 to \$100,000. The center shall monitor the balance in the resident fund account and increase the surety bond as necessary to meet the needs of the center. This shall be the responsibility of the Office Manager. The Office Manager shall report to the Administer and QA committee monthly any problems in maintaining the required bond. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.		9-9-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bonnie Lewis

TITLE

Administrator

(X6) DATE

10-1-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=B	<p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that all residents had a dignified dining experience. Findings include:</p> <p>Lunch observation on 9/1/09 between 12:15 PM and 12:45 PM revealed the following;</p> <ol style="list-style-type: none"> 1. One table of residents were served their lunch on cafeteria trays while three other tables of residents were served their meals restaurant style. 2. Aide, E4 was observed feeding SSR2 standing up. 3. Meals came out of the kitchen in a manner that caused residents at the same table to watch other residents eat their lunch before fellow residents received their meal. 	F 241	<p>Resident # SSR2 remains in the center. <i>10-16-09</i></p> <p>Other residents identified have been assessed during meals and are receiving their meals at the same time. Dietary department has reorganized the meal delivery to provide proper serving of meals by table. E4 and other employees are sitting at the time of feeding any resident. In-servicing shall be completed of nursing staff on or before October 16, 2009 on resident dignity with meal service.</p> <p>Random audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.</p>		
F 280 SS=B	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the</p>	F 280	<p>Resident R15 remains at the center, <i>9-18-09</i> and is currently being invited to attend the care plan review. Also permission has been obtained from the resident to invite the primary contact. The center shall obtain permission from current residents prior to inviting their primary contacts and provide an</p>		

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F 280	<p>Continued From page 2</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review it was determined that the facility failed to have a system to notify and invite one cognitively intact resident (R15) out of 24 sampled residents of their care plan meetings. In addition, the facility failed to obtain permission from R15 prior to inviting a family member.</p> <p>Findings include:</p> <p>Review of R15's admission and most recent quarterly Minimum Data Set (MDS) assessments dated 11/24/08 and 8/14/09 respectively indicated that the resident was cognitively intact and independent in daily decision making.</p> <p>Review of R15 ' s records revealed care plan meetings were held on 3/3/09, 6/8/09, and 9/2/09 and that both the resident and the primary contact, R15 ' s daughter were notified of the meetings. An interview with R15 on 9/3/09 at 3:45 PM revealed that she does not recall being notified or invited to an Interdisciplinary Care Plan</p>	F 280	<p>invitation to the residents to attend their care conference.</p> <p>Random audits shall be completed by the Social Services Director over the next 90 days to determine compliance. The Social Services Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.</p>		

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F 280	Continued From page 3 (ICP) . Review of the facility's Care Plan and Assessment policy indicated that the facility will notify the resident and primary contact prior to the ICP meetings, encourage them to attend, and solicit their input. Additionally, the policy indicated that the primary contact will be invited with the customer's permission. Although facility records documented that both the resident and the primary contact were invited to the above ICP meetings, this documentation conflicted with what was actually completed. Additionally, the records lacked evidence that the facility obtained the resident's permission prior to inviting the primary contact to the ICP meetings. An interview with the Director of Social Services, E10 on 9/8/09 at 11 AM revealed that that facility's process was to invite the primary contact of each resident to the ICP meeting, however, resident permission was not obtained prior to the invitation. Additionally, the system failed to notify and invite a resident, who was competent to participate in the ICP meetings. Findings reviewed with the Administrator, E1 on 9/9/09 at 8:30 AM.	F 280			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Resident's R6 and R13 remain in the center. Both residents' continue to receive care as ordered by the physician. Both residents' have been reviewed by the ICP team and their plans of care have been updated as necessary to reflect their current level of care. Current resident's physician orders		10-16-09

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F 309	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to provide the necessary care and services for two (R6 and R13) out of 24 sampled residents. R6 was not administered oxygen as ordered following a discharge from the hospital for pneumonia. R13 was ordered a nutritional supplement, however, this supplement was not initiated for five days.</p> <p>Findings include:</p> <p>1. R6 was originally admitted to the facility on 9/4/08 with diagnosis including hypothyroidism, history of pneumonia, and renal failure. The resident was readmitted to the facility on 6/17/09 from the hospital with diagnosis of pneumonia and an order for oxygen at 2 liters per nasal cannula (NC), titrate saturation (level of oxygen in the blood stream) to > (greater than) 92%. The next day, on 6/18/9, order was changed to titrate to saturation of > 91%.</p> <p>The post hospitalization chest x-ray (CXR) dated 6/29/09 indicated modest right middle lobe infiltrate and was reported to the Nurse Practitioner, NP1. No new order was obtained.</p> <p>Review of Medication Administration Record (MAR) for remainder of June 2009 documented resident 's oxygen saturation level of 94%.</p> <p>Review of the July, August, and September's monthly Physician's Order Sheets (POS) revealed</p>			F 309	<p>have been reviewed to determine compliance. In-servicing shall be held on or before October 16, 2009, for licensed nursing staff on transcription and follow through with physician orders. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance</p>		

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F 309	<p>Continued From page 5</p> <p>oxygen ordered at 2 liters per NC-titrate saturation > 92%.</p> <p>Subsequent CXR dated 7/31/09 indicated slight lower lobe atelectasis versus infiltrate and was reported to NP1. No new order was obtained.</p> <p>Review of the July, August, and September 2009 MARs revealed that the above order was incorrectly transcribed by a facility staff as PRN (as needed) and the MARs lacked evidence the oxygen saturation was maintained as ordered. There was no indication that the resident received oxygen daily during these months.</p> <p>Upon surveyor inquiry on 9/8/09, the facility contacted the attending physician, MD1 and on 9/8/09, the oxygen order was discontinued and an order was obtained to check resident's pulse ox every shift for one week. The first pulse oximetry obtained on 9/8/09 at approximately 3:35 PM was 98% on room air.</p> <p>Although the oxygen was ordered to maintain oxygen > 91%, the facility failed to ensure that the oxygen was administered and the pulse oximetry was obtained.</p> <p>2. R13 had skin breakdown and was on a nutritional supplement Hi-Cal. A note by the dietitian (E9) on 9/1/09 suggested that the Hi-Cal supplement be changed to Mighty Shake and provided on the lunch tray because the resident did not like the Hi-Cal.</p> <p>On 9/3/09 the nurse obtained a telephone order from the physician to make this change. Lunch observation on 9/8/09 revealed that R13 did not receive the Mighty Shake at lunch. An interview</p>	F 309			

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F 309	Continued From page 6 with the nurse (E6) revealed that there was no dietary communication form initiated. E6 corrected this immediately and arranged for R13 to get a Mighty Shake. The resident did not receive the Mighty Shake for 5 days.	F 309			
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one out of 24 residents (R23) the facility failed to assess a pressure sore weekly to promote healing. Findings include: R23 was admitted to the facility on 5/29/09 with a stage II pressure ulcer. Review of the pressure ulcer assessments in the clinical record revealed that the facility was not completing weekly assessments. The assessments were dated 6/6/09, 6/20/09 (14 days later), 7/5/09 (15 days later), and 7/19/09 (14 days later). The pressure ulcer continued to heal during this period of time. An interview with the unit manager (E8) confirmed that the pressure ulcer assessments were not done weekly. It was further revealed that the facility was using their computer charting to document the weekly assessment. This computer	F 314	Resident #23 no longer resides in the center. Current residents with pressure ulcers have been reviewed for appropriate documentation related to weekly assessments. The center has put the paper assessments back in place, to replace computerized assessments until the system issue is resolved. In-servicing shall be completed on or before October 16, 2009, for licensed nursing staff on pressure ulcer weekly assessments. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. The DON shall report monthly to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	10-16-09	

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F 314	Continued From page 7 system failed to alert nursing staff of the next assessment due date. The facility is now using a paper tracking system until the computer issue can be resolved.	F 314			
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that the facility failed to ensure one (R19) out of 24 sampled residents received meals that met their individual needs. Findings include: Review of R19's September 2009 monthly POS indicated that the resident was to receive applesauce and prune juice three times per day. Observation of the lunch tray on 9/4/09 included a bowl of applesauce, however, no prune juice. In addition, a bowl of green beans was on the tray. Review of resident 's meal ticket indicated that the resident dislikes included green beans. An interview with R19 during lunch on 9/4/09 revealed that she was unable to eat the green beans due to the skin of the vegetable. An interview with the Food Services Director, E11 on 9/4/09 at approximately 1:15 PM confirmed that the resident should have had the prune juice on the tray and that the resident should not have been served the green beans.	F 365	Resident #19 no longer resides in the center. Current residents have been reviewed to determine compliance with providing residents with needed nutritional items ordered by the physician and also maintaining the resident's likes and dislikes. In-servicing shall be completed on or before October 9, 2009, for dietary staff on following resident diet slips. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the Food Service Director/designee. The FSD shall report monthly to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	10-9-09	
F 387	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN	F 387			

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F 387 SS=D	<p>Continued From page 8 VISITS</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Cross refer to F 501 Based on record review and interview it was determined that three (R15, R21, and R7) out of 24 residents did not have documented physician visits at the required frequency. Findings include:</p> <ol style="list-style-type: none"> 1. R15 was admitted to the facility on 11/19/08. The physician documented a history and physical note on 11/20/09. The next progress note was 3/5/09, over 90 days later. This resident should have had documented visits every 30 days for the first 90 days and then every 60 days. 2. R21 was admitted to the facility on 10/6/08. The physician documented a history and physical note on 10/6/08. The first progress note was 1/15/09, over 60 days. The subsequent progress note was dated 9/1/09, almost eight months after the prior note. This resident should have had documented visits every 30 days for the first 90 days and then every 60 days. 3. R7 was admitted to the facility on 1/15/09. On 8/31/09 the most recent progress note on the 	F 387	<p>Resident's # 7, 15, and 21 remain in the center and continue to receive care per physician orders. The physician for resident R15 no longer attends at the center. Resident R15 is being attended by a new physician. The physician for residents R7 and R21 will no longer be assigned new admissions to focus on existing case load.</p> <p>In-servicing shall be completed on or before October 2, 2009, for facility Unit Clerks on tracking physician visits. Random audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.</p>	10-2-09	

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F 387	Continued From page 9 clinical record was 2/3/09. An interview on 9/2/09 with E7, the medical records clerk, revealed that the doctor came in last night (9/1/09) and wrote a progress note. She confirmed that there were no other progress notes available. This resident should have had documented visits every 30 days for the first 90 days and then every 60 days.	F 387			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that staff washed their hands properly after direct resident contact. Findings include: 1. On 9/1/09 at 8:26 AM nurse E3 was administering medications to SSR1 which included eye drops. Upon exiting the room E3 washed her hands and turned off the faucet with bare hands potentially recontaminating her hands. The nurse should have used a paper towel to turn off the faucet as indicated in facility policy and current infection control standards. 2. On 9/3/09 at 11:30 AM aide E5 repositioned R11 for the nurse who was doing the treatment. Upon exiting the room E5 washed her hand and turned off the faucet with bare hands potentially recontaminating her hands. The aide should have used a paper towel to turn off the faucet as indicated in facility policy and current infection	F 444	Resident SSR1 no longer resides in the center. Resident R11 remains in the center and continues to receive care as ordered by the physician. Employee E3 and E5 have been retrained on infection control practices of the center. In-servicing shall be completed on or before October 16, 2009, for facility staff on infection control. Random rounds and audits shall be completed over the next 90 days to determine compliance with infection control practices. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.		10-16-09

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F 444	Continued From page 10 control standards.	F 444			
F 497 SS=D	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of the Certified Nursing Aide (C.N.A.) in-service records, it was determined that the facility failed to ensure the continuing competence of nurse aides by maintaining no less than 12 hours of in-service per year. Findings include: 1. C.N.A. #E18 completed 10.0 hours of in-service for the current anniversary year from date of hire. 2. C.N.A. #E19 completed 7.5 hours of in-service for the current anniversary year from date of hire.	F 497	Employee's E18 and E19 remain employed at the center and have completed the necessary in-servicing to maintain their certification. Current employee records have been reviewed to determine that no others have been affected. In-servicing shall be held routinely for Nursing Assistants to ensure that the 12 hour in-service requirement per year is obtained. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the Nurse Practice Educator/designee. The Nurse Practice Educator shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.		9-11-09
F 501 SS=F	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.	F 501	The center has obtained a new Medical Director. Current and new residents shall receive visits by a physician in compliance with the regulations. The		10-9-09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2009
NAME OF PROVIDER OR SUPPLIER MILFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MARVEL ROAD MILFORD, DE 19963		
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F 501	<p>Continued From page 11</p> <p>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that the medical director coordinated the medical care of residents, ensured the provision of services by physicians conducting the physician visits at the required frequency and ensured the physician attendance at quarterly quality assurance meetings. (R15, R21, and R7) Findings include:</p> <p>Cross refer to F 387</p> <ol style="list-style-type: none"> 1. R15 was admitted to the facility on 11/19/08. The physician documented a history and physical note on 11/20/09. The next progress note was 3/5/09, over 90 days later. This resident should have had documented visits every 30 days for the first 90 days and then every 60 days. 2. R21 was admitted to the facility on 10/6/08. The physician documented a history and physical note on 10/6/08. The first progress note was 1/15/09, over 60 days. The subsequent progress note was dated 9/1/09, almost eight months after the prior note. This resident should have had documented visits every 30 days for the first 90 days and then every 60 days. 3. R7 was admitted to the facility on 1/15/09. On 8/31/09 the most recent progress note on the clinical record was 2/3/09. An interview on 9/2/09 with E7, the medical records clerk, revealed that 	F 501	<p>new Medical Director will monitor and manage physicians visit requirements as well as participate in Quality Assurance meetings.</p> <p>In-servicing shall be completed for the facility unit clerks on tracking physician visits on or before October 2, 2009.</p> <p>Random audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.</p> <p>The DON shall report to the Administrator and QA committee monthly any variance in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.</p>		

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F 501	Continued From page 12 the doctor came in last night (9/1/09) and wrote a progress note. She confirmed that there were no other progress notes available. This resident should have had documented visits every 30 days for the first 90 days and then every 60 days. Cross refer to F 520 4. An interview with the administrator (E1) on 9/9/09 revealed that the physician designated by the facility last attended a quality assurance meeting on 1/9/09. The facility continues to conduct meetings on a monthly basis without the Medical Director present. This is a repeat deficiency from the survey ending 9/24/08.	F 501			
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	The facility has hired a new Medical Director and this Medical Director will participate and attend Quality Assurance meetings.	10-9-09	

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F 520	<p>Continued From page 13</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Cross refer F 501 Based on interview it was determined that the facility failed to maintain a quality assessment and assurance committee that met quarterly consisting of the physician designated by the facility. Findings include:</p> <p>An interview with the administrator (E1) on 9/9/09 revealed that the physician designated by the facility last attended a quality assurance meeting on 1/9/09. The facility continues to conduct meetings on a monthly basis without the Medical Director present.</p> <p>This is a repeat deficiency from the survey ending 9/24/08.</p>	F 520			



**DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

LTC Residents Protection
OCT 06 2009
Director's Office

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: 9-9-09

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey and complaint visit was conducted at this facility from August 31, 2009 through September 9, 2009. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirty-one (131). The sample totaled twenty four (24) residents which included a review of twenty-one (21) active and three (3) closed residents' clinical records. There was a sub sample of 2 residents for observation and interview.</p>	
3201	Delaware Regulations for Skilled and Intermediate Care Nursing Facilities	
3201.6.0	Services to Residents:	
3201.6.1	General Services:	
3201.6.1.1	The nursing facility shall provide to all	



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NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: 9-9-09

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.2.4	<p>residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F309, F314, F387, F444 and 501.</p> <p>The facility shall purchase a surety bond to assure the security of resident funds.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F161.</p>	<p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F309, F314, F387, F444 and 501.</p> <p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F161.</p>
3201.9.0	<p>Quality Assessment and Assurance</p> <p>Each facility shall have a quality assessment and assurance committee which shall include the director of nursing, a physician and at least 3 other members of the facility's staff.</p> <p>This requirement is not met as evidenced by:</p>	
3201.9.1		



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	<p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F520.</p> <p><u>16 Delaware Code, Chapter 11, Sub Chapter II</u></p> <p><u>§1121 Patient's Rights (1)</u></p> <p>Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F241.</p>	<p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F520.</p> <p>Cross refer to the CMS 2567-L survey report date completed 9/9/09, F241.</p>